NATIONAL FARMERS UNION PROPERTY AND CASUALTY COMPANY

11900 EAST CORNELL AVENUE

AURORA, COLORADO 80014-3194

NAIC COMPANY # 01683

MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2002

COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

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Prepared by

John J. Postolowski, CIE, MA, FLMI, AIRC, ACS

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Market Conduct Examiners

April 16, 2003

The Honorable Doug Dean
Commissioner of Insurance
State of Colorado
1560 Broadway Suite 850
Denver, Colorado 80202

Commissioner:

In accordance with sections 10-1-203 and 10-3-1106, C.R.S., an examination of selected underwriting and claims practices in the automobile insurance business of National Farmers Union Property and Casualty Company has been conducted. The company's records were examined at its corporate office located at 11900 East Cornell Avenue, Aurora, Colorado 80014-3194.

The examination covered a twelve-month period from January 1, 2002 to December 31, 2002.

A report of the examination of National Farmers Union Property and Casualty Company is herein respectfully submitted.

John J. Postolowski, CIE, MA, FLMI, AIRC, ACS

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MARKET CONDUCT EXAMINATION REPORT OF NATIONAL FARMERS UNION PROPERTY AND CASUALTY COMPANY

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COMPANY PROFILE

National Farmers Union Property and Casualty ("PACCO") writes a variety of personal lines policies in several states. Those policies include auto, Homeowners, farm and "main street" commercial. The states in which PACCO writes these policies are Colorado, Kansas, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Utah and Wyoming. PACCO also sells its agribusiness package policy in these states, but PACCO is withdrawing from writing this line beginning with April 1, 2003, renewals.

In 2001, PACCO wrote $67, 238,000 in private passenger automobile premium nationwide and $12, 025,000 in PPA premium in Colorado.

PACCO was incorporated in Utah in 1945 under the name National Farmers Union Automobile and Casualty Company ("ACCO") and became licensed that same year in Colorado. ACCO changed its name to National Farmers Union Property and Casualty Company in 1950. PACCO was redomesticated to Colorado in 1984. Its stock is now wholly-owned by OneBeacon Insurance Group LLC as the result of its acquisition by a predecessor of OneBeacon in 1998.

PACCO is licensed to do business in the following jurisdictions: Alaska, Arizona, Arkansas, California, Colorado, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming.

PACCO is license to sell the following lines of business: accident and health, livestock, plate glass, steam boiler and machinery, burglary and theft, fidelity and surety, motor vehicle – full coverage, workmen's compensation, liability, personal property floaters, mortgage, credit, credit – A&H, professional malpractice, fire and lightning, extended coverage, hail on growing crops, earthquake, aircraft, inland marine, ocean marine, homeowners multiple peril, commercial multiple peril, farmowners multiple peril.

In 1989, PACCO assumed the property business of Farmers Union Mutual Insurance Company of Colorado prior to that company's dissolution.

The Company reported $12,025,000* in private passenger automobile written premiums in Colorado during 2001, representing a .48% market share of all private passenger automobile insurance written in Colorado during 2001.

* 2001 Colorado Market Share and Loss Ratio Report

PURPOSE AND SCOPE OF EXAMINATION

The purpose of this examination was to audit the business practices of National Farmers Union Property and Casualty Company (hereinafter referred to as Company) as applicable to private passenger automobile insurance in the State of Colorado. This procedure is in accordance with section 10-1-203, C.R.S., which empowers the Commissioner to examine insurance companies. The findings in this report, including all work product developed in the production of this report, are the sole property of the Colorado Division of Insurance.

The purpose of the examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to private passenger automobile insurance laws. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

This examination was governed by, and performed in accordance with, procedures developed by the National Association of Insurance Commissioners and the Colorado Division of Insurance. In reviewing material for this report the examiners relied primarily on records and material maintained by the Company. The examination covers one twelve-month period of the Company's operations, from January 1, 2002 to December 31, 2002.

File sampling was based on a review of underwriting and claim files that were systematically selected using Audit Command Language (ACL) software and computer data files provided by the company. Sample sizes were chosen based on guidance from procedures developed by the National Association of Insurance Commissioners. Upon review of each file, any concerns or discrepancies were noted on comment forms. These comment forms were delivered to the Company for review. Once the Company was advised of a finding contained in a comment form, the Company had the opportunity to respond. For each finding the Company was requested to agree, disagree or otherwise justify the Company's noted action. At the conclusion of each sample, the Company was provided a summary of the findings for that sample. The report of the examination is, in general, a report by exception. Therefore, much of the material reviewed will not be contained in this written report, as references to any practices, procedures, or files that manifested no improprieties were omitted.

An error tolerance level of plus or minus $10.00 was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other system a $0 tolerance level was applied in order to identify possible system errors. Additionally, a $0 tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's rates on file with the Colorado Division of Insurance.

The examination included review of the following four Company operations:

1. Complaint Handling
2. Underwriting
3. Rating
4. Claims Practices

Some unacceptable or non-complying practices may not have been discovered in the course of this examination. Failure to identify or criticize specific Company practices does not constitute acceptance by the Colorado Division of Insurance. Examination findings may result in administrative action by the Division of Insurance.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of eight (8) issues arising from the Company's apparent noncompliance with Colorado law, statutes and regulations concerning all property and casualty insurers operating in Colorado. These eight (8) issues fell into three (3) main categories as follows:

Operations:

This one (1) issue arises from Colorado statutory and regulatory requirements regarding the maintenance of records for market conduct examinations. This issue of noncompliance is identified as follows:

- Failure to maintain records for market conduct examinations.

Complaint Handling:

In the area of complaint handling , no compliance issues are addressed in this report.

Underwriting:

These three (3) issues arise from Colorado statutory and regulatory requirements regarding no-fault cost containment requirements, stating the actual reason for proposing the action, offers to exclude the person with the claim or driving record problem and application of filed rating rules. The issues of noncompliance are identified as follows:

- Failure, in some cases, to state the actual reason for proposing the action.
- Failure, in some cases, to offer to exclude the person with the claim or driving record problem and continue coverage for another household member.
- Misapplication, in some cases, of filed rating rules.

Rating:

In the area of rating, no compliance issues are addressed in this report.

Claims Practices:

These four (4) issues arise from Colorado statutory and regulatory requirements regarding statements included with claim payments, equitable settlement of claims, notice required when there is a delay in payment of PIP benefits and timely payment of PIP benefits. The issues of noncompliance are identified as follows:

- Failure, in some cases, to include a statement setting forth the coverage under which claims payments are being made.
- Failure, in some cases, to provide equitable settlements of claims in which liability has become reasonably clear.

- Failure, in some cases, to send a letter to the claimant and/or health care provider setting forth reasons why additional time is needed to investigate a claim.

- Failure, in some cases, to pay personal injury protection benefits in the timely manner required by Colorado law.

NATIONAL FARMERS UNION PROPERTY AND CASUALTY COMPANY

PERTINENT FACTUAL FINDINGS

MARKET CONDUCT EXAMINATION REPORT

PERTINENT FACTUAL FINDINGS

OPERATIONS

Issue A: Failure to maintain records for market conduct examinations.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of Section 10-1-109, C.R.S., October 1, 1995, states, in part: …

III. RULE

B. RECORDS REQUIRED FOR MARKET CONDUCT PURPOSES

1. Every insurer/carrier or related entity licensed to do business in this state shall maintain its books, records, documents and other business records so that the insurer's /carrier's or related entity's claims, rating, underwriting, marketing, complaint, and producer licensing records are readily available to the commissioner.

3. Claim files shall be maintained so as to show clearly the inception, handling and disposition of each claim. A claim file shall be retained for the calendar year in which it is closed plus the next two calendar years.

Records required to be retained by this regulation may be maintained in paper, photograph, microprocess, magnetic, mechanical or electronic media, or by any process which accurately reproduces or forms a durable medium for the reproduction of a record. A company shall be in compliance with this section if it can produce the data which was contained on the original document, if there was a paper document, in a form which accurately represents a record of communications between the insured and the company or accurately reflects a transaction or event.

Records required to be retained by this regulation shall be readily available upon request by the commissioner or a designee. Failure to produce and provide a record within a reasonable time frame shall be deemed a violation of this regulation, unless the insurer or related entity can demonstrate that there is a reasonable justification for that delay.

PIP Paid Claims

Population	Sample Size	Number of Exceptions	Percentage to Sample
368	**50**	**11**	**22%**

An examination of fifty (50) files, representing 14% of all PIP claims paid by the Company during the exam period revealed eleven (11) exceptions (22% of the sample) wherein the company failed to maintain adequate records for market conduct examination. In the majority of these eleven (11) exceptions, the Company failed to maintain copies of bills from health care providers.

Recommendation No. 1:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Regulation 1-1-7. In the event the Company is unable to provide such documentation, it should be required to provide evidence demonstrating that the Company has amended its procedures to ensure compliance with Colorado insurance law.

PERTINENT FACTUAL FINDINGS

UNDERWRITING

Issue B: Failure, in some cases, to state the actual reason for proposing the action.

Colorado Insurance Regulation 5-2-3, Auto Accident Reparations Act (No-Fault) Rules and Regulations, jointly promulgated by the Commissioner of Insurance and the Executive Director of the Department of Revenue under the authority of §§ 42-1-204, 10-4-704, 10-4-718, 10-4-719.7 and 10-1-109, C.R.S., provides, in part:

Section 3 Rules

D. Rules Limiting Insurer's Action to Refuse to Write Cancel, Nonrenew, Increase Premium, Surcharge, Or Reduce Coverages

2. Notice of proposed actions.

a. A proposal to cancel, nonrenew, increase the premium or reduce coverage under a private passenger motor vehicle insurance policy shall state the actual reason for proposing such action in the notice required by §10-4-720(2), C.R.S. Only one notice is required to be sent to the insured whose incident resulted in the proposed action. The statement of reasons shall be clear and specific so that a reasonable person can understand it. The insurer shall clearly describe its underwriting rule, policy or guideline which is the basis for the proposed action. A simple recitation of dates and incidents, without further detail, is not acceptable and may cause the insurer's proposed action to be disallowed.

Polices Cancelled In The First 59 Days

Population	Sample Size	Number of Exceptions	Percentage to Sample
69	**50**	**5**	**10%**

An examination of fifty (50) files, representing 72% of all policies cancelled by the Company in the first 59 days during the exam period revealed five (5) exceptions (10% of the sample) wherein the company failed to state the actual reason for proposing the cancellation.

Recommendation No. 2:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Regulation 5-2-3. In the event the Company is unable to provide such documentation, it should be required to provide evidence demonstrating that the Company has amended its procedures to ensure compliance with Colorado insurance law.

Issue C: Failure, in some cases, to offer to exclude the person with the claim or driving record problem and continue coverage for another household member. Prior Issue J: Failure to provide policyholders with proper notice when canceling (this is from another exam).

Section 10-4-719.7(1.5), C.R.S., Refusal to write, changes in, cancellation, or nonrenewal of policies prohibited, states in part:

(b) (I) No insurer shall refuse to write a complying policy solely because of the claim or driving record of one or more but fewer than all of the persons residing in the household of the named insured.

(II) An insurer shall offer to exclude any person by name pursuant to section 10-4-721 in the household if such person's driving record and claim experience would justify the refusal by such insurer to write a policy for such person if such person were applying in such person's own name and not as part of a household.

Polices Cancelled In The First 59 Days

Population	Sample Size	Number of Exceptions	Percentage to Sample
69	50	3	6%

An examination of fifty (50) files, representing 72% of all policies cancelled by the Company in the first 59 days during the exam period revealed three (3) exceptions (6% of the sample) wherein the company failed to offer to exclude the person with the claim or driving record problem and continue coverage for another household member.

Recommendation No. 3:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-4-719.7, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide written evidence demonstrating that the Company has adopted and implemented procedures to ensure compliance with Colorado insurance law.

In the Market Conduct examination for the period January 1, 1998, through December 31, 1998, the Company was cited for failure to provide policyholders with proper notice when canceling. The violation resulted in Recommendation #10, that the Company comply with Colorado insurance law. Failure to comply with the recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue D: Misapplication, in some cases, of filed rating rules.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(f) (II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

Section 10-4-401, C.R.S.,

(3) The kinds of insurance subject to this part 4 shall be divided into two classes, as follows:

(b) Type II kinds of insurance, regulated by open competition between insurers, including fire, casualty, inland marine, title, medical malpractice by a joint underwriting association regulated under part 9 of this article, credit, workers' compensation and employer's liability incidental thereto and written in connection therewith for rates filed by insurers, and all other kinds of insurance that are subject to this part 4 and not specified in paragraph (a) of this subsection (3), including the expense and profit components of workers' compensation insurance, which shall be subject to all the provisions of this part 4 except for sections 10-4-405 and 10-4-406. Concurrent with the effective date of new rates, type II insurers shall file rating data, as provided in section 10-4-403, with the commissioner; except that credit life and credit accident and health insurers shall file schedules of premium rates pursuant to sections 10-10-109 and 10-10-110.

Colorado Insurance Regulation 5-1-10, Rate And Rule Filing Submissions Property And Casualty Insurance, states in part:

Section 5. Rules

C. Rule Filing General Requirements

2. Every property and casualty company, including those writing workers' compensation and title insurance, is required by this regulation to provide a list of minimum premiums, schedule of rates, rating plans, dividend plans, individual risk modification plans, deductible plans, rating classifications, territories, rating rules, rate manuals and every modification of any of the foregoing which it proposes to use. Such filings must state the proposed effective date thereof, and indicate the character and extent of the coverage contemplated.

The rating rules filed by National Farmers Union for the period under examination state in part:

608 ACCIDENT SURCHARGE PLAN – effective 11/01/2001

All private passenger automobiles, farm trucks, farm semi tractor/trailers, non-farm truck, pickups, utility vehicles, motor homes and antique autos insured are subject to the surcharge plan.

1. Coverages subject to the plan. This plan applies to BI/PD, PIP and collision coverages.

2. Definitions

   A. Experience Period

      1) New Business – 36 months ending with the date the application is written.

      2) Renewal Business – 36 months ending on the date of the policy renewal.

   B. Chargeable Accident means a motor vehicle accident which has resulted in a payment of **$1,000 or more ($500 or more for accidents that occurred before 2/1/98)** to, by, or on behalf of the insured or any operator of the insured's motor vehicle, excluding any payment for damages to which the uninsured motorists, PIP or comprehensive coverages would apply. **The $1,000 threshold also applies to any reclassification actions (cancellations, or beginning to surcharge an accident) on any new business or renewal effective 2/1/98 or later, regardless of the date of the accident.**

      Subsequent Rating – An accident shall be chargeable as of the date the Company has recorded payments totaling $1,000 or more. Motor vehicle accidents involving any of the following circumstance shall not be considered as chargeable accidents:

Renewals

Population	Sample Size	Number of Exceptions	Percentage to Sample
7081	**100**	**9**	**9%**

An examination of one hundred (100) files, representing 1% of all renewals by the Company during the exam period revealed nine (9) exceptions (9% of the sample) wherein the company failed to rate the renewal policy according to the rating rules on file with the Division of Insurance. In all nine (9) of these exceptions the Company failed to apply the appropriate accident surcharge to some while applying it to others, resulting in unfair treatment to consumers.

Recommendation No. 4:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104 and 10-4-401, C.R.S. and Colorado Regulation 5-1-10. In the event the Company is unable to provide such documentation, it should be required to provide written evidence demonstrating that the Company has adopted and implemented procedures to comply with Colorado law.

PERTINENT FACTUAL FINDINGS

CLAIMS PRACTICES

Issue E: Failure, in some cases, to include a statement setting forth the coverage under which claims payments are being made. Prior Issue R: Making claim payments to insureds not accompanied by statement setting forth the coverage under which the payments are being made (this is from another exam).

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(X) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made; or

First Party Paid Claims

Population	Sample Size	Number of Exceptions	Percentage to Sample
2579	50	10	20%

An examination of fifty (50) files, representing 2% of all first party paid claims during the exam period revealed ten (10) exceptions (20% of the sample) wherein the company failed to include a statement setting forth the coverage under which claims payments are being made.

Total Loss Claims

Population	Sample Size	Number of Exceptions	Percentage to Sample
105	50	22	44%

An examination of fifty (50) files, representing 48% of all total loss claims during the exam period revealed twenty two (22) exceptions (44% of the sample) wherein the company failed to include a statement setting forth the coverage under which claims payments are being made.

Recommendation No. 5:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide written evidence demonstrating that the Company has adopted and implemented procedures that ensure compliance with this statute.

In the Market Conduct examination for the period January 1, 1998, through December 31, 1998, the Company was cited for making claim payments to insureds not accompanied by statement setting forth the coverage under which the payments are being made. The violation resulted in Recommendation #18, that the Company comply with Colorado insurance law. Failure to comply with the recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue F: Failure, in some cases, to provide equitable settlements of claims in which liability has become reasonably clear. Prior Issue T: Failure to effectuate prompt, fair and equitable claim settlements (this is from another exam).

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonable clear: or

PIP Paid Claims

Population	Sample Size	Number of Exceptions	Percentage to Sample
368	**50**	**10**	**20%**

An examination of fifty (50) files, representing 14% of all PIP paid claims during the exam period revealed ten (10) exceptions (20% of the sample) wherein the Company failed to settle the claims equitably. These exceptions resulted in overpayments in amounts ranging from $45.00 to $1,200.00.

Recommendation No. 6:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S.. In the event the Company is unable to provide such documentation, it should be required to provide evidence demonstrating that the Company has adopted and implemented procedures that will ensure future compliance with Colorado insurance law.

In the Market Conduct examination for the period January 1, 1998, through December 31, 1998, the Company was cited for failure to effectuate, prompt, fair and equitable claims settlements. The violation resulted in Recommendation #20, that the Company comply with Colorado insurance law. Failure to comply with the recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue G: Failure, in some cases, to send a letter to the claimant and/or health care provider setting forth reasons why additional time is needed to investigate a claim.

Colorado Insurance Regulation 5-2-8, Timely payment of Personal Injury Protection benefits, promulgated by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-4-704, 10-4-708(1.3) and 10-3-1110(1), C.R.S., effective November 1, 1997, amended September 1, 2000, provides, in part: …

Section 3. Rule

A. Prompt Investigation of PIP Claims

Section 10-3-1104(1)(h)(III), C.R.S., requires insurers to adopt and implement reasonable standards for prompt investigation of claims. An insurer is also required to promptly investigate a claim while it is accumulating claim's expense.

Whenever an insurer requires that an application for benefits form be submitted by an injured party, the insurer shall forward the form to the injured party upon notification of the injury.

When an investigation is incomplete or is otherwise continued, the insurer shall, within 30 days after the documents are received as described in C. below and every 30 days thereafter, send to the claimant or the claimant's representative, and the health care provider, if applicable, a letter setting forth the reasons additional time is needed for investigation.

Where additional information is required to complete an investigation, the insurer shall request such information, specifically listing the items needed to complete the investigation. A copy of such request shall be delivered to the claimant, the claimant's representative, the health care provider or other person or entity most likely in possession of the required information.

D. Notice Requirements

If an insurer does not pay a claim for benefits under §10-4-706, C.R.S. within 30 days of receipt of the appropriate documents described in this regulation and as set forth in §10-4-708, C.R.S., the insurer shall immediately notify the PIP claimant or the claimant's representative and the health care provider, if applicable, of the reason(s) the claim has not been paid. If the claim has not been paid because an investigation is underway, the insurer shall document in the claim file the actions being taken to investigate the claim and the efforts being made to promptly conclude the investigation.

PIP Paid Claims

Population	Sample Size	Number of Exceptions	Percentage to Sample
368	**50**	**26**	**52%**

An examination of fifty (50) files, representing 14 % of all PIP paid claim files with payments issued during the exam period showed twenty-six (26) exceptions (52% of the sample) wherein the Company failed to send a letter to the claimant and/or health care provider setting forth reasons why additional time is needed to investigate a claim.

Recommendation No. 7:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Regulation 5-2-8. In the event the Company is unable to provide such documentation, it should be required to provide evidence demonstrating that the Company has amended its procedure to ensure compliance with Colorado insurance law.

Issue H: Failure, in some cases, to pay personal injury protection benefits in the timely manner required by Colorado law. Prior Issue P: Delay of PIP benefit payments (this is from another exam).

Section 10-4-708(1), C.R.S., Prompt payment of direct benefits, provides, in part: …

> Payment of benefits under the coverages enumerated in section 10-4-706 (1)(b) to (1)(e) or alternatively, as applicable, section 10-4-706(2) or (3) shall be made on a monthly basis. Benefits for any period are overdue if not paid within thirty days after insurer receives reasonable proof of the fact and amount of expenses incurred during that period; except that an insurer may accumulate claims for periods not exceeding one month, and benefits are not overdue if paid within fifteen days after the period of accumulation. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within thirty days after such proof is received by the insurer. Any part or all of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within thirty days after such proof is received by the insurer. In the event that the insurer fails to pay such benefits when due, the person entitled to such benefits may bring an action in contract to recover the same.

Colorado Insurance Regulation 5-2-8, Timely payment of Personal Injury Protection benefits, promulgated by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-4-704, 10-4-708(1.3) and 10-3-1110(1), C.R.S., effective November 1, 1997, amended September 1, 2000, provides, in part: …

Section 3. Rule

> B. Prompt Payment of PIP Benefits
>
> Section 10-4-708(1), C.R.S., provides that benefits under the coverages enumerated in § 10-4-706, C.R.S., are overdue if not paid within 30 days after the insurer receives reasonable proof of the fact and amount of the expenses incurred.
>
> Section 10-4-708(1), C.R.S., allows for the accumulation of claims expense for periods not exceeding one month and provides that benefits are not overdue if paid within 15 days after the end of a defined period of accumulation. An insurer is permitted by this statute to pay a bill within 15 days after the end of a defined accumulation period only when there is a reasonable likelihood that multiple providers are involved and more than one bill is received during the accumulation period.
>
> C. Requirements Establishing Proof of the Fact and Amount of Expenses Incurred
>
> 1. Medical and Rehabilitative PIP benefits
>
> In the usual case, for purposes of triggering the 30-day time period described in § 10-4-708(1), C.R.S., the following documents are sufficient to establish reasonable proof of the fact and amount of the expenses incurred for covered medical and rehabilitative PIP benefits:
>
> a. A properly executed application for benefits from the PIP claimant; and

b. An initial notice to the insurer from the provider of benefits which meets the requirements of § 10-4-708.5, C.R.S. or a billing statement for the procedure or treatment which complies with § 10-4-708.6, C.R.S., and includes pursuant to § 10-4-708.5 the following:

(1) The name and address of the treating health care provider;
(2) The evaluation of diagnosis, and the medical procedure performed or the medical treatment provided; and
(3) An itemized statement of charges corresponding to the medical service or treatment provided along with corresponding dates of service.

PIP Paid Claims

Population	Sample Size	Number of Exceptions	Percentage to Sample
368	**50**	**26**	**52%**

An examination of fifty (50) files, representing 14% of all PIP paid claims during the exam period revealed twenty-six (26) exceptions (52% of the sample) wherein the Company failed to make payment in the timely manner required by Colorado law. In all twenty-six (26) exceptions, the Company made payment later than thirty days after receipt of proof of the fact and amount of expenses incurred.

Recommendation No. 8:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-4-708, C.R.S. and Colorado Regulation 5-2-8. In the event the Company is unable to provide such documentation, it should be required to provide evidence demonstrating that the Company has amended its procedure to ensure compliance with Colorado insurance law.

In the Market Conduct examination for the period January 1, 1998, through December 31, 1998, the Company was cited for delay of PIP benefit payments. The violation resulted in Recommendation #16, that the Company provide evidence that it has reviewed all procedures related to timeliness of handling claims, investigation of claims, acknowledgment of claims, accumulation of bills, and documentation of claim files and has implemented all necessary changes to assure compliance in each area. Failure to comply with the recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

SUMMARY OF RECOMMENDATIONS

For

NATIONAL FARMERS UNION PROPERTY AND CASUALTY COMPANY

ISSUE	RECOMMENDATION NUMBER	PAGE NUMBER
Issue A: Failure to maintain records for market conduct examinations.	**1**	**12**
Issue B: Failure, in some cases, to state the actual reason for proposing the action.	**2**	**14**
Issue C: Failure, in some cases, to offer to exclude the person with the claim or driving record problem and continue coverage for another household member. Prior Issue J: Failure to provide policyholders with proper notice when canceling (this is from another exam).	**3**	**15**
Issue D: Misapplication, in some cases, of filed rating rules.	**4**	**17**
Issue E: Failure, in some cases, to include a statement setting forth the coverage under which claims payments are being made. Prior Issue R: Making claim payments to insureds not accompanied by statement setting forth the coverage under which the payments are being made (this is from another exam).	**5**	**19**
Issue F: Failure, in some cases, to provide equitable settlements of claims in which liability has become reasonably clear. Prior Issue T: Failure to effectuate prompt, fair and equitable claim settlements (this is from another exam).	**6**	**20**
Issue G: Failure, in some cases, to send a letter to the claimant and/or health care provider setting forth reasons why additional time is needed to investigate a claim.	**7**	**22**
Issue H: Failure, in some cases, to pay personal injury protection benefits in the timely manner required by Colorado law. Prior Issue P: Delay of PIP benefit payments (this is from another exam).	**8**	**24**

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